STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295021	A. BUILDING _____ B. WING _____	C 11/02/2010

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SOUTHERN NEVADA MEDICAL AND REHABILITATION CENTER	2945 CASA VEGAS STREET LAS VEGAS, NV 89109

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare complaint survey conducted at your facility on October 13, October 14, and November 02, 2010, in accordance with 42 Chapter IV Part 483 Requirement for Long Term Care Facilities. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state of local laws. CPT # NV00026630: This complaint contained three allegations: The first allegation was related to a resident developing a Stage 4 pressure ulcer, and was substantiated (see Tag 314). The deficient care event (wound development) had occurred at the facility and the facility had since made corrections to prevent the deficient care from recurring, also described in Tag F314. Due to both the deficient care event's occurrence and the facility's corrective action, this citation will be managed as past non-compliance at the time of the current survey (Section 7510.1 of the State Operating Manual). The second allegation was related to a resident's fall and was substantiated (see F-Tags 272, 279, and 323). The third allegation was related to general uncleanliness of the facility, and was not substantiated through observations and through interviews with six residents and facility staff.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 000	Continued From page 1 CPT # NV00026624: This complaint contained two allegations: The first allegation concerned incontinence care and odors, and the second allegation asserted a resident did not receive a sponge bath or shower until she had been at the facility three days. These allegations were not substantiated through clinical record review, observations of eleven resident rooms, and interviews with six residents. The following regulatory deficiencies were identified:	F 000		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;	F 272		11/23/10

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F 272	Continued From page 2 Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct an initial standardized assessment of a resident's functional capacity and health status (Resident #2). Findings include: Resident #2 was admitted to the facility on 7/22/10, with diagnoses including acute cerebral vascular accident, status post heart catheterization and left sided hemiparesis. The Admission Interview and Assessment form, dated 7/22/10, documented Resident #2 was at high risk for falls. The documentation indicated Resident #2 had an ambulation problem, used artifical devices, and was confused and disorientated. The medical record lacked documentation the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs) and a Comprehensive care plan had been completed. On 10/13/10, at 4:25 PM, Employee #4 was not able to locate a completed MDS 2.0 in the medical record. Employee #4 stated, "It was one I missed." The employee communicated the RAPs were also not completed. Employee #4 indicated	F 272		

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F 272	Continued From page 3 the facility had 21 days based on the MDS to complete the comprehensive care plan which was developed from the documentation in the MDS assessment. The employee indicated that when a resident with high fall risk was admitted, the protocol was to complete the fall risk assessment with intervention on the back of the form and develop an interim plan of care until the MDS assessment was completed. The facility's MDS Assessment policy, dated 3/2006, documented the interdisciplinary team will complete an assessment of each resident as part of the RAI (resident assessment instrument) process to assure date accuracy for its state-specific version of the MDS within the required time frames according to applicable law and regulations.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		11/23/10

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F 279	Continued From page 4 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess a resident and to develop, review, and revise the resident's comprehensive care plan (Resident #2). Findings include: Resident #2 was admitted to the facility on 7/22/10, with diagnoses including acute cerebral vascular accident, status post heart catheterization and left sided hemiparesis. The Admission Interview and Assessment form, dated 7/22/10, documented Resident #2 was at high risk for falls. The documentation indicated Resident #2 had ambulation problem, used artifical devices and was confused and disorientated. The medical record lacked documentation the Minimum Data Set (MDS), Resident Assessment Protocols (RAP) and a Comprehensive care plan had been completed. On 10/13/10, at 4:25 PM, Employee #4 was not able to locate a completed MDS 2.0 in the medical record. Employee #4 stated, "It was one I missed." She indicated the RAP was not done either. Employee #4 indicated the facility had 21 days based on the MDS to complete the comprehensive care plan, which was developed from the documentation in the MDS assessment.	F 279		

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The facility's Care Plan Process policy, dated 3/2006, documented the interim plan of care facilitates care until the Interdisciplinary Plan of Care is developed. The Interdisciplinary team meets and reviews the Care Plan seven days after the closure date of the initial MDS.

Daily skilled nurse's notes, dated 8/28/10, documented Resident #2 was alert, and had a unsteady gait and balance problem.

The nurse's note documented Resident #2 was found on floor face down with one side rail down. The resident had a skin tear on his left elbow and an abrasion and hematoma on his left eyebrow. According to the documentation, Resident #2 complained of pain on the right side of his neck and left shoulder pain. The documentation indicated Resident #2 was placed back into bed and "side rails are all up." There was no documentation in the nurse's notes the call light was in place prior to or at the time of the fall.

On 10/13/10 at 4:25 PM, Employee #4 was not able to locate physician's orders for the use of side rails or documentation in the medical record to explain why one side rail was in place the day of Resident #2's fall.

On 8/28/10, a physician's order on was received non-emergent transfer of Resident # 2 to the acute care hospital secondary to status post fall with head trauma.

On 8/29/10, a physician's order was received to cleanse left eyebrow wound with wound cleanser pat dry and apply triple antibiotic ointment and cover with a clean dry dressing daily for 30 days. Cleanse left elbow skim tear with wound cleanser,

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pat dry apply triple antibiotic ointment and cover with a clean dry dressing daily for 30 days.

The interim plan of care, dated 7/22/10, documented Resident #2 was a fall risk. The goal was to minimize falls by encouraging the use of the call light. The interim care plan lacked documentation to determine if Resident #2 was to have side rails or an air mattress in place.

On 10/14/10, the facility provided documentation, dated 8/28/10, entitled, Patient/Resident Incident /Accident Investigation Worksheet. The documentation indicated Resident #2 had an unwitnessed fall at 8:10 AM on 8/28/10, in his room. According to the documentation Resident #2 indicated he was eating his breakfast and slid off the bed. The information on the form documented Resident #2 had restraint ordered for side rails up times 2 secondary to the air mattress on the morning he fell.

The medical record contained a comprehensive care plan 8/29/10. The care plan documented Resident #2 was at risk for falls related to physical impairment. Approaches included bed in low position and falling star program (Facility's fall risk notification for staff).

The medical record for Resident #2 lacked a physician's orders for the use of side rails, an assessment for side rails use, documentation on the interim plan of care or comprehensive care plan side rails were being used.

Resident #2's medical record lacked a physician's order for an air mattress, documentation in the nurse's notes, interim plan of care, comprehensive care plan, treatment sheets or

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F 279	Continued From page 7 medication administration record an air mattress was being used for Resident #2. .	F 279		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, documentation review, and interview, the facility failed to ensure a resident having a pressure ulcer received necessary treatment to promote healing through: 1) notifying the physician of wound condition changes; 2) implementing preventive interventions in a timely manner; and 3) reviewing and revising the pressure ulcer care plan (Resident #2). Findings include: Resident #2 was admitted to the facility on 7/22/10, with diagnoses including acute cerebrovascular accident, hemiplegia, Stage 1 coccyx pressure ulcer, coronary artery disease, and hypertension. On 7/23/10, documentation related to the resident's coccyx pressure ulcer read as follows	F 314		11/23/10

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on the Wound Care Progress Notes form: "coccyx pressure ulcer Stage 1, 5 cm (centimeters) x 10 cm; red D/I (dry and intact) nonblanchable with pink periwound. labs reviewed. Dr.___, aware, new orders received."

A care plan for Resident #2 was created on 7/23/10, with the identified Problem as "Pressure area: Stage 1 coccyx." The goal was written as "skin will remain clean and dry and area will heal over the next 90 days. The following approaches were included in the care plan: "perform treatment per order; keep family/responsible party and MD informed of resident's progress."

On 7/25/10 Wound Care Progress Notes read, "coccyx pressure ulcer Stage 2, 5 cm x 10 cm; superficial, open, 100% red, nonblanchable. Dr.__ aware." These progress notes were transcribed onto a Weekly Wound Tracking Worksheet.

The Director of Wound Care (Employee #5) explained that the Weekly Wound Tracking Worksheet was a tool utilized by the facility for physicians to receive updates of the status of residents' wounds. However, there was no documented evidence in the record (including physician progress notes) that the physician knew Resident #2's wound's condition changed and was now an open Stage 2 pressure ulcer.

In an interview with one of the facility's Physician Assistants (PAC #1) on 11/2/10 at 1:30 PM, the PAC reported that the facility's PACs and physicians did not use the Weekly Wound Tracking Worksheet as a tool to obtain information about changes in residents' wound conditions. The PACs/physicians instead relied

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on the Wound Care Team to verbally tell them about any changes. PAC #1 acknowledged that whenever this communication occurred between the Wound Care Team and a PAC, it was not normally documented in the resident's record.

According to the facility's "Wound Care Policies and Procedures" policy, dated 10/2009, "Abnormal findings/changes should be reported to the resident's primary care provider and family/responsible party by the licensed nurse per facility protocol. Documentation of the primary care provider notification, orders received, family notification, and resident response to any treatment should follow facility as well."

The 8/7/10 Wound Care Progress Notes read, "Coccyx pressure ulcer D/I, 8 cm x 12.4 cm, 60 % deep purple, 40 % red nonblanchable base, purple periwound, min (minimum) serous drainage. (PAC) aware; new orders received. Low air loss mattress." (The resident received a low air loss mattress on 8/18/10, eleven days after the order.)

Review of physician orders confirmed an order on 8/7/10 to "D/C (discontinue) current tx (treatment) to coccyx ulcer (which was to apply Calazime to the wound every shift); cleanse coccyx ulcer with wound cleanser, pat dry, apply Santyl and cover with dry, clean dressing for 30 days." This order was written on the August Wound Treatment and Progress Record, but there was no evidence the order was being carried out by the Wound Care Team until 8/21/10, when the treatment was initialed each day from 8/21/10 to 8/31/10. Employee #5 and the Acting DON (Director of Nursing) (Employee #6) could not provide evidence that this treatment order was carried out

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F 314	Continued From page 10 from 8/7/10 through 8/20/10. Wound Progress Notes, dated 8/8/10, read as follows: "Coccyx pressure ulcer, unstageable, 11 cm x 10 cm, 50 % black, 30 % red base, 20 % purple tissue, moist, min serous drainage, periwound pink." On 8/15/10, the description of the coccyx pressure ulcer on the Wound Progress Notes read, "Stage 2, 6.5 cm x 9 cm, 40 % red base, 30 % yellow slough, 30 % brown eschar, moderate serous sanguinous drainage, periwound purple." The facility's "Staging of Pressure Ulcers - National Pressure Ulcer Advisor Panel - NPUAP," dated 10/2009, listed definitions of pressure ulcer definitions. According to the policy, a Stage 2 ulcer has "partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister." A Stage 3 ulcer was defined as "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling." A Stage 4 pressure ulcer has "full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling." An "Unstageable" ulcer is defined as "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined....For	F 314		

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MDS (minimum data set) coding, eschar covered wounds are coded as Stage 4."

According to these definitions, Resident #2's coccyx pressure ulcer on 8/15/10, with evidence of slough and eschar, should have been staged at Stage 3 or Stage 4. There was no documented evidence the physician and family members were informed about the change of condition of the wound. The PAC indicated that PACs should be notified if a wound begins to show evidence of slough or eschar.

The facility's "Pressure Ulcers" policy, dated 10/2009, included the following procedures: "Re-evaluate pressure ulcers at least weekly. If the resident's condition, or the condition of the wound deteriorates, or if there is no significant progress within a reasonable time frame, the treatment plan should be re-evaluated. If the treatment plan is not changed, documentation should be provided as to why the current treatment plan is being maintained." There was no evidence in the record that the resident's treatment plan was re-evaluated, in conjunction with the PAC, when the pressure ulcer exhibited slough and eschar.

The 8/22/10 Wound Progress Notes included the following description: "Coccyx pressure ulcer, Stage 2, 6 cm x 8.4 cm, 50 % moist red base, 50 % yellow slough, pink macerated periwound."

The 08/29/10 description on the Wound Progress Notes read, "Coccyx pressure ulcer, Stage 2, 5.3 cm x 8.3 cm x 0.3 cm, moist, 40 % yellow slough, 60% red base, periwound red, scant serosanguinous drainage." There was no documented evidence of physician notification,

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F 314	Continued From page 12 when the ulcer developed a depth dimension. On 9/12/10 Wound Progress Notes were, "Coccyx pressure ulcer, Stage 4, 5.3 cm x 7.8 cm x 1.4 cm, 30 % yellow slough, 60 % red base, 10 % red tissue moist, min serous drainage, periwound pink." The facility's "Wound Evaluations" policy, dated 10/2009, outlined the following: "Evaluation of wounds will be performed on admission, weekly, and on discovery...Evaluation results are communicated to the members of the care team through documentation, case conference, and care planning." A review of Resident #2's Pressure Ulcer care plan revealed it was never updated after 7/23/10. There was no evidence that wound care audits were being conducted by the Director of Wound Care with regard to those he supervised, or by the facility through a performance improvement process. Audit forms were available in the facility, but they were not being used, and this was confirmed by both Employees #5 and #6. According to the facility's "Wound Care Policies and Procedures - Reference" policy, dated 10/2009, "Evaluation of in-house acquired pressure ulcers should be ongoing as part of the quality assurance/process improvement process with management of the pressure ulcers occurring daily in accordance with primary care provider orders/nursing interventions and information reviewed on a weekly, monthly, and quarterly basis to assist in identifying trends, management, validation that interventions are in place, and a process for monitoring sustained improvement and effectiveness."	F 314		

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F 314	Continued From page 13 Facility's Corrective Action: The facility's correction action was to: 1) implement weekly audits of all wound care treatments; 2) ensure PACs/physicians are aware of any wound condition changes, through accurate/consistent Staging definitions by the wound care team and documentation of this notification in residents' clinical records; 3) ensure air mattresses are provided as ordered in a timely manner; 4) ensure pressure ulcer care plans are reviewed and revised with changes in wound conditions; and 5) track, monitor, and evaluate wound care as an ongoing part of the facility's performance improvement process. No POC (plan of correction) response is required for this tag.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident's environment was fully assessed and evaluated for needed supervision to prevent avoidable accidents	F 323		11/23/10

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	295021	A. BUILDING _____ B. WING _____	C 11/02/2010

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(Resident #2).

Findings include:

Resident #2 was admitted to the facility on 7/22/10, with diagnoses including acute cerebral vascular accident, status post heart catheterization and left sided weakness.

The Admission Interview and Assessment form, dated 7/22/10, documented Resident #2 was at high risk for falls. The documentation indicated Resident #2 had ambulation problem, used artifical devices and was confused and disorientated. The documentation stated, "Any patient that Nurse determines is high risk for falls will be treated as such."

The fall risk evaluation, dated 7/22/10, documented Resident #2 scored a 12. According to the documentation a resident scoring 10 or higher should have interventions initiated and the interventions documented on the form and on the resident's care plan.

The medical record lacked documentation the Minimum Data Set (MDS), Resident Assessment Protocols (RAP) and a Comprehensive care plan had been completed.

On 10/13/10 at 4:25 PM, Employee #4 was not able to locate a completed MDS 2.0 in the medical record. Employee #4 stated, "It was one I missed." She indicated the RAP was not done either. Employee #4 indicated the facility had 21 days based on the MDS to complete the comprehensive care plan which was developed from the documentation in the MDS assessment. Employee #4 indicated when a resident with high

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risk of fall was admitted the process was to complete the fall risk assessment with intervention on the back of the form and also to develop an interim plan of care to be used until the MDS assessment was completed.

The facility's Care Plan Process policy, dated 3/2006, documented the interim plan of care facilitates care until the Interdisciplinary Plan of Care is developed. The Interdisciplinary team meets and reviews the Care Plan seven days after the closure date of the initial MDS.

Daily skilled nurse's notes, dated 8/28/10, documented Resident #2 was alert, and had a unsteady gait and balance problem. The nurse's note documented Resident #2 was found on floor face down with one side rail down. The resident had a skin tear on his left elbow and an abrasion and hematoma on his left eyebrow. According to the documentation Resident #2 complained of pain on the right side of his neck and left shoulder pain. The documentation indicated Resident #2 was placed back into bed and "side rails are all up." There was no documentation in the nurse's notes the call light was in place prior to or at the time of the fall in accordance with the interim plan of care. The daily nurse's notes did not address whether or not Resident #2 had an air mattress in place at the time or the fall.

On 10/13/10 at 4:25 PM Employee #4 was not able to locate physician's orders for the use of side rails or documentation in the medical record to explain why one side rail was in place the day of Resident #2's fall.

On 8/28/10, a physician's order on was received non- emergent transfer of Resident # 2 to the

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acute care hospital secondary to status post fall with head trauma.

On 8/29/10, a physician's order was received to cleanse left eyebrow wound with wound cleanser pat dry and apply triple antibiotic ointment and cover with a clean dry dressing daily for 30 days. Cleanse left elbow skim tear with wound cleanser, pat dry apply triple antibiotic ointment and cover with a clean dry dressing daily for 30 days.

The interim plan of care, dated 7/22/10, documented Resident #2 was a fall risk. The goal was to minimize falls by encouraging the use of the call light. The interim care plan lacked documentation Resident #2 was using side rails or an air mattress.

On 10/14/10, the facility provided documentation dated 8/28/10, entitled "Patient/Resident Incident /Accident Investigation Worksheet." The documentation indicated Resident #2 had an unwitnessed fall at 8:10 AM on 8/28/10 in his room. The documentation indicated Resident #2 verbalized he was eating his breakfast and slid off the bed. The information on the form indicated Resident #2 had restraint ordered for side rails up times 2 secondary to the air mattress on the morning he fell.

The medical record for Resident #2 lacked a physician's orders for the use of side rails,an assessment for side rails use, documentation on the interim plan of care or comprehensive care plan side rails were being used.

Resident #2's medical record lacked a physician's order for an air mattress, documentation in the nurse's notes, interim plan of care,

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F 323	Continued From page 17 comprehensive care plan, treatment sheets or medication administration record an air mattress was being used for Resident #2.	F 323		